The Relationship of Prayer and Internal Religiosity to Mental and Spiritual Well-being

William M. Gabler

A Research Paper

Submitted in Partial Fulfillment of the
Requirements for the
Master of Sciences Degree
in
Guidance and Counseling

Approved: Two Semester Credits

_____

Robert Salt Phd., Research Advisor

The Graduate School
University of Wisconsin-Stout
May, 2004

The Graduate School
University of Wisconsin-Stout
Menomonie, WI 54751

ABSTRACT

Writer: Last Name: Gabler First Name: William Middle Initial: M.

Title: The Relationship of Prayer and Internal Religiosity to Mental and Spiritual Well-being

Graduate Major: Guidance and Counseling – Mental Health

Research Advisor: Dr. Bob Salt Month/Year: 5/04

No. of Pages: 51

Style Manual: Publication Manual of the American Psychological Association: Fourth Addition

The purpose of this study was to explore the relationship between internal religiosity, including prayer, to well-being, which includes religious and existential well-being. A convenience sample of 60 Behavioral Health hospital patients from a Midwestern hospital were invited to participate in this study. Three instruments were used in addition to twelve demographic questions. All instruments used a likert scale and the demographic questions were multiple choice.

The Intrinsic Religious Motivation Scale (1972) was used to determine the level of the person's internal religious commitment. The Structure of Prayer Scale (1997) was used to determine the participant's prayer preference. The Spiritual Well-Being Scale (1982) was used to determine a person's self reflected well-being personally and spiritually. The instruments were correlated using a Pearson Correlation.

This study provides health professionals with correlated data about which clients are better able to adjust to the stresses of being mentally ill. Correlations may lead to research that supports causal relationships and allows health professionals to provide better support options for their clients who are mentally ill. Future studies could focus on understanding the relationship between a specific mental illnesses and religious or spiritual well-being. The future research could also foster greater internal religiosity and encourage the mentally ill to use specific types of prayer as an effective intervention to increase patient well-being.

TABLE OF CONTENTS

CHAPTER ONE

Introduction

Spirituality is the part of self concerned with religious or supernatural values (Merriam-Webster, 1993). More specifically a spiritual experience happens when a person's consciousness and awareness of the self, others, and the world is felt at a deeper level (Moberg, 2001). Moberg (2001) sees three spiritual needs: meaning and purpose of life, unconditional love, and experience of forgiveness. Clearly people can meet these needs in many different ways. Muslims find the meaning of life in the Koran, where Christians find the meaning of life in the death of Jesus, where Jews find the meaning of life in the Torah, while others might find the meaning of life meditating in nature. Unconditional love and forgiveness are also needs that are fulfilled differently across cultures and religions. One method many people use to fulfill the need of unconditional love and forgiveness is prayer.

Most research on prayer has dealt with prayer as a coping strategy or as evidence of healing (McKinney & McKinney, 1999). While some would look at the effects of prayer for the definition, others look to the action to define prayer. Prayer is an address to God in word or thought (Merriam-Webster, 1993). More specifically prayer is the human capacity to experience the intertwining of the seen and unseen of human and nonhuman life

(Palmer, 1983). People use various methods to experience this intertwining. Specific methods include: confession, petition, ritual, meditation-improvement, habit, and compassionate petition (Luckow, A., Ladd, K. L., Spilka, B., McIntosh, D. N., Parks, C., & Laforett, D. 1997). No matter what type of prayer people choose to carry out they do so to experience and feel a sense of communication with something greater than the self, God.

This type of communication has been part of human life for thousands and thousands of years and continues today. Decades of polls show that nearly ninety percent of Americans pray (Poloma, 1993). In a study of church going Christians, 98 percent report praying several times a week (Bade and Cook, 1997). In another study of psychology and communication undergraduates, eighty-four percent reported praying from “a few times a year” to “several times a day” (McKinney and McKinney, 2001). In addition to the samples of studies that cite high participant prayer practices, most religions engage in one or more of the prayer types listed in the research of Luckow et al., (1997). Prayer is part of life for many people; it should be part of psychological studies.

Even though humans have lived on the Earth for hundreds of thousands of years, only within the last 200 years has our species started to formally study human behavior from a modern

western scientific perspective (psychology). Even more recently, the last 100 years, researchers have begun the study of the relationship between spirituality or religion and psychology. The gift of modern science, especially research, gives humans the ability to begin to understand prayer (the communication with the divine in our daily lives).

History

Theories about spirituality or religion and the human psyche began when the science of psychology started. Early theories by Freud and his followers undermined the validity of religious beliefs (Wallwork & Wallwork, 1990). Early psychoanalysis did not experiment with spirituality, and was irreligious (Wallwork & Wallwork, 1990). Erik Erikson acknowledged that religion did reaffirm ego strength, but said that a person who had completed therapy with an analyst would not be religious (Wallwork & Wallwork, 1990). Theories of psychology have grown since Freud and Erikson, and other psychological views of religion have become important. While these men were trying to separate science and religion, William James was having a different impact.

William James was the “original thinker in and between the disciplines of physiology, psychology and philosophy” (Stanford, 2003). In the late 1800’s and early 1900’s he argued that religion is accessible to humans (Stanford, 2003). He argued

that religion is accessible through human experiences (McNeil, 1997). These experiences can be measured scientifically (McNeil, 1997). James takes the opposite view of Freud and Erickson. Instead of seeing science as something that disproves religion or spirituality, he integrates science with spirituality and uses science to better understand the experience of religion.

In the early 1900's Carl Jung also integrated science and religion or spirituality. Jung believed that instincts came from an archetype waiting to be activated (Purdue, 2004). He called this the collective unconscious (Purdue, 2004). Jung believed that spirituality is one of these instincts that come out of the collective unconscious (Purdue, 2004). While this belief still explains spirituality or religion as part of the psyche, it is not as openly hostile as Freud's views. As time went on more and more people began trying to understand the relationship between psychology and religion or spirituality.

Kemp (1996) named many organizations that integrate psychology and religion: In 1953 the Christian Association for Psychological Studies was founded; Academy of Religion and Mental Health was formed in 1954; American Foundation of Religion and Psychiatry was formed 1958; and around the 50's and 60's many other groups were formed within larger organizations.

Years later another important movement was forming.

“Transpersonal Psychology” was formally founded as a distinct perspective in psychology by Abraham Maslow and Anthony Sutich in 1969 with the publication of the *Journal of Transpersonal Psychology”* (Association for Transpersonal Psychology, 2004). Transpersonal Psychology was also discussed in 1980 at the APA convention (Kemp, 1996). This movement became crucial to the relationship between religion and psychology because there was more focus on understanding people’s experiences. Understanding other’s experiences began with Maslow's theories (Kemp, 1996). These theories opened people’s minds to a more genuine way of understanding people’s spiritual experiences.

Psychological Theory

Frances Vaughan (Mishlove, 1987) explained in the film *Thinking allowed*, that people have layers. All people are physical, emotional, mental, existential, and transpersonal, with each layer showing a deeper part of the true person. The model is built on the idea that people's fullest potential is becoming self-actualized. She stated this view goes deeper into people than the psychoanalytic ego can explain. She believed we are not deeply fulfilled until we learn to get in touch with that deepest part of our self.

When exploring the relationship between religion and existential well-being, Margaret Poloma (1993) suggested that

existential needs are best met by experiencing intimacy with the divine. Jone's (1996) supports Poloma when asserting, "Psychology could be enriched by more explicit exploration of the interface of religion with its scientific and applied activities" (p. 141). The relationship between spirituality or religion and psychology can be better understood. The following study will survey the expanding research on these relationships and explore prayer and well-being in a population of mental health patients.

Statement of the Problem

Scales used to gain information about prayer and well-being are well studied. The Spiritual Well-Being Scale has norms for nine religions, counseling patients, college students, sociopathic convicts, pastors, seminarians, medical patients, and caregivers for the terminally ill (Bufford, R. K., Paloutizian, R. F., & Ellison, C. W., 1991). The Structure of Prayer Scale has norms for a Christian college, a secular college, a conservative evangelical seminary, and cancer patients (Luckow et al., 1997). The Intrinsic Religious Motivation Scale has norms only for members of parishes (Hoge, D. R. (1972). While these studies have well-established norms, these three scales have not established any norms for mental health inpatients.

This study will explore the norms for a mental health inpatient population at a Midwestern hospital over all three measures, during the summer semester 2002. The study will also correlate the other measures and some demographic items with the measures. This will give the researcher a better understanding of this population. The correlation studies will help the researcher understand which mental health clients tend to live lives with greater feelings of well-being. This information may be used in future studies to explore cause and effect relationships between factors that may lead to elevated feelings of well-being.

Research Questions

The study will help provide insight into the levels of well-being and internal religiosity or prayer for mental health inpatients. The study will also provide insight into the relationship between well-being and internal religiosity or prayer in this population.

Hospital patients on the Behavioral Health Unit of a midwestern hospital will be invited to participate in this study. Three tested measurement instruments will be used to measure the variables: internal religiosity, affinity to types of prayer, and well-being (existentially and spiritually). The researcher hypothesizes that the levels of well-being and

internal religiosity will match that of the norms for the general population. The researcher also hypothesizes that subjective existential well-being will be positively correlated with subjective religious well-being within the sample. The Spiritual Well Being Scale will be positively correlated with The Intrinsic Religious Motivation Scale within the same sample and stronger prayer affinity will be positively correlated with both of the above scales.

Definition of Terms

Spiritual and religious are both terms that often are used interchangeably because they are so similar. According to Moberg (2001) spirituality and religion are significantly correlated in a moderate way. In this study many things discussed will apply to both spirituality and religion. Other times in the study the differences will be highlighted. Spirituality is a broad term that refers to many religious activities, like prayer, and inspirations (Moberg, 2001). Spirituality also refers to some non-religious activities such as: communication with animal spirits, divination of kings, fortune telling, possessions, and human fate (Moberg, 2001). Religion is more focused on both personal beliefs and organizational practices; examples included church activities and commitment to doctrines and church customs (Moberg, 2001).

Religiosity is a term that describes the role religion plays in a person's life. External religiosity refers to attendance at religious services or other outward signs of commitment to religion. Intrinsic religiosity tries to objectively define the internal affects of religion on life. When religious beliefs affect life decisions or actions regularly, the person has a high intrinsic religiosity. Often religiosity includes prayer. Prayer has many forms. Prayer can be meditative, confessional, petitional, ritual, and habitual.

Subjective existential well-being and subjective religious well-being are measured on the Spiritual Well-Being Scale. These variables measure the subjective view of the client. Existential well-being measures a person's feelings of happiness in relation to her or his current life. Subjective religious well-being is a measure of a person's feelings about God.

Research Limitations and Assumptions:

Measuring instruments may be inappropriate for some hospital patients. While the measures have face validity and are well researched, the participant's health may not allow for him/her to accurately describe his/her current or regular situation in reference to the measures. Mental health issues may especially affect one's ability to respond to psychological

measures. The measures are not appropriate for any patient with a diagnosis of an active psychosis.

Participants are limited to patients who attend a coping skills group. There is no control over what type of patient attends the group. Certain diagnoses maybe overly represented while others may be under represented. Other unknown factors may also prevent hospital patients from participating in this study. The lack of certain groups could skew the data.

Finally, all measures assume people pray. People who do not pray can sometimes mark down answers that would reflect that fact, but not all questions allow the participant to acknowledge lack of prayer.

CHAPTER TWO

Literature Review

Studies on the affects of spirituality, religion, or prayer in the lives of people are clearly showing positive effects (Hales, 2003). The positive findings on physical health and mental health are well documented and will be discussed in this chapter. The chapter will also discuss research outlining the differences between internal and external commitment to spirituality or religion. Types of prayer and their benefits will be discussed in this chapter. The research reveals the clear health benefits of spirituality, or religion and illustrates some techniques that are effective in gaining the health benefits.

Relationship Between Physical Health and Prayer or Religion

Kenneth Pargament (1997) surveyed over sixty studies looking at the relationship between aspects of religious coping and stress. Most studies involved medical stress; a few measured general stress. A decrease in stress was measured with factors like quality of life, length of disease, happiness, level of pain, etc. The religious coping measures looked at many factors including: church attendance, frequency of prayer, strength of religious beliefs, and Bible reading. Sixty-eight percent of the studies found religious coping strategies made a

positive impact on medical stress factors, four percent of the strategies showed a negative impact, and twenty-eight percent found no relationship. Studies in the majority 68% of the discussed research covered a broad range of physical health stresses. Examples included a study of 154 chronically ill male veteran patients who were rated on a religious commitment scale. One year after the religious commitment scale rating the mortality rate was checked. Higher religious commitment correlated significantly to a lowered mortality rate. Another study measured the strength of religious beliefs in terminally ill cancer patients and found that stronger religious beliefs were positively correlated with less fear of death (r=.77). Research is showing that a person's personal “relationship with God” often has positive effects on his/her medical stress and health.

Larry Dossey (1996) asserted that prayer complements medical techniques. According to Dr. Dossey, research indicates that when random groups of religious people were selected to pray for random groups of sick people, the sick (who were being prayed for) had better recovery than a control group. Dr. Dossey’s assertion claims that the internal spiritual/religious actions of others do benefit a sick person in much the same way as the sick person’s spiritual/religious actions.

His assertion is confirmed in the research of Dr. Targ, director of the Complementary Medicine Research Institute (Waring, 2000). Twenty of forty patients with advanced AIDS were prayed for six days a week for ten weeks by experienced healers from Christian, Jewish, Buddhist, Native American, shamanic, and other traditions. The healers had a photo of the patients and knew their names and the healing schedule was randomized and rotated weekly. The study controlled for age, T-cell count, and illness history. Four areas saw significant differences; Two patients (in the prayed for group) verses twelve patient (not prayed for group) developed new AIDS-defining illnesses, doctor visits were less (185 vs. 260), fewer days were spent in the hospital (10 vs. 68), and those who were prayed for also showed marked improvement in mood (Waring, 2000).

Relationship Between Mental Health and Religious Commitment

Larson, Sherrill, Lyons, Craigie, Thielman, Greenwold, and Larson (1992) assessed all measures of religious commitment in the American Journal of Psychiatry and Archives of General Psychiatry from 1978 to 1989. The authors found that a great majority of the measures assessed reported a positive relationship between religious commitment and mental health (Larson et al., 1992). The effects of prayer in medical

research clearly are replicated in past psychological research; this same trend is seen again almost ten years later.

In the empirical literature review of Matthews, D.A., McCullough, M.E., Larson, D.B., Koenig, H.G., Swyers, J.P., Milano, M.G. (1998) the relationship between religious factors and physical and mental health was explored. Religious factors included: frequency of religious attendance, private religious involvement, and relying on one's religious beliefs as a source of strength and coping. Physical and mental factors included: prevention of illness, coping with illnesses, and recovery from illness. Studies reviewed had at least one measure from religious factors and at least one factor from physical and mental factors. “About 80% of the published studies find that religious commitment is related to better health status and outcomes” (Matthews et al., 1998). The religious factors discussed above are a combination of internal and external religious factors; specific focus on internal religious factors deepens the understanding of the relationship between spirituality or religion and health.

Poloma (1993) took part in forming and analyzing the Akron Area Survey and later a national Gallup poll. Both polls indicated a perceived relationship with God is more important to mental well-being than denomination, religious beliefs, or church attendance (Poloma, 1993). This is further supported by

research that shows intrinsic religious faith can help older people recover from mental disorders, according to a Duke psychiatrist (Duke University, 1998). In the discussed research a point scale was used to measure intrinsic religious faith. Every ten-point increase in intrinsic religious faith equated to a seventy percent increase in recovery time from depression (Duke University, 1998). A ten-point rise in intrinsic religious faith was paired with a one hundred percent increase in the speed of recovery for older patients (Duke University, 1998). This study from Duke University is not typical of most research due to its focus on internal faith, most research focuses on external faith.

Internal factors are much more difficult for researchers to measure and therefore decrease the credibility of the research. Research on the relationship between spirituality or religion and health more often measures external spiritual or religious actions (Matthews & Clark, 1998). These external actions are easier to measure and are referred to as religiosity or more specifically external religiosity. Examples of external religiosity are church attendance or membership in a Bible study. While internal religious factors, like prayer, may also be present during external religious activities, detecting and measuring internal factors is much more difficult than determining how often one attends church.

Religious Factors and Prayer

Religiosity is usually referred to as external, but Matthews and Clark (1998) referred to an inner relationship with God when discussing intrinsic religiosity. Internal and external religiosities are both discussed in research. Matthews and Clark (1998) stated that both internal and external religiosity do improve health. Most research surveyed seems to show stronger and more consistent correlations to health and happiness when intrinsic religiosity is measured. Intrinsic and extrinsic religiosity both apply to prayer. Prayer is both religious and spiritual; prayer consists of thoughts, attitudes, and actions that express or experience a connection to something rich and deep in humans (McCullough and Larson, 1999).

Matthews and Clark (1998) and Poloma (1993) both outlined four types of prayer. "Colloquial prayer" is defined as talking to God in one's own words. This type of prayer does involve a more intrinsic religiosity. Colloquial prayer, measured on a six-item scale, was found to have a significant positive relationship to life satisfaction (r=.16), existential well-being (r=.29), happiness (r=.17) and religious satisfaction (r=.48) (Poloma and Pendleton, 1989).

"Petitionary prayer" is the type of prayer where people ask for personal needs. Matthews and Clark (1998) discussed a few

studies that provided evidence that petitionary prayer helps people cope with illness. One of the studies they discuss found that 91% of a sample of 200 women used petitional prayer as the most frequent coping response to medical problems. Poloma and Pendleton (1989) measured petitionary prayer on a two-item scale. The frequency people used petitionary prayer was positively related to life satisfaction (r=.09) and existential well-being (r=.12).

"Ritual prayer" is the most formal type of prayer and includes repeating a prepared script. Research specific to this type of prayer is uncommon. McCullough and Larson, (1999) state, “Preliminary evidence suggests that ritual prayer might be associated with slightly lower well-being.”

“Meditative prayer” includes relaxing, contemplative prayer, and being still, quiet, and “open to God”. “Meditative-contemplative prayer appears to reflect the styles of religious coping (e.g., seeking spiritual support, spiritual support)” (McCullough and Larson, 1999).

Poloma (1993) collected data from a Gallup Poll, from any person who responded that they prayed at least occasionally. Fourteen questions separated prayer types into colloquial, petitionary, ritual, and meditative. The study found that meditative prayer had the strongest relationship with perceived closeness to God when compared to the other types of prayer

(r=.43). Poloma (1993) also found that all prayer types positively correlated with personal feelings of closeness to God. Frequency of prayer also positively correlated with increases in perceived closeness to God (Poloma, 1993).

Religious People Have Better Mental Health

Prayer and religion positively affect mental health, as supported by research in the field. Religious people (members of an organized religion) are less likely to become depressed than their non-religious counterparts (Matthews & Clark, 1998). A 1990 study of 451 people found a significant negative relationship between high levels of religious involvement (ex. Church attendance) and higher scores on the depression scale (Matthews & Clark, 1998). "Men with low religious involvement scored twice as high on the depression scale as their more religious counterparts" (Matthews & Clark, 1998). Additional studies the authors discuss showed lower levels of depression for those who had greater religious commitment across gender and denomination. While depression research is the most common, Matthews and Clark (1998) found that prayer or religious commitment also affected the likelihood of other mental illnesses.

The frequency of any mental illness for religious people is half that of the general population (Matthews & Clark, 1998).

Matthew and Clark (1998) provided strong support that religious commitment and prayer not only decreased one's chances of mental illness, but also helped people recover from mental illness. Matthews and Clark (1998) cited a Missouri study of four hospitals where 275 in-patients with schizophrenia were tested for religious affiliation and worship attendance. Findings indicated that any affiliation decreased the likelihood of re-hospitalization. These affects were even more pronounced when family encouraged worship services.

Professionals want to help their clients recover, cope, and have higher life satisfaction. Religious activity, especially intrinsic, is associated positively with life satisfaction (Ayele, Mulligan, Gheorghiu, & Reyes-Ortiz, 1999). This is true even when age, gender, health, and marital status were controlled for a sample of ill adults and physicians working at a hospital (Ayele, Mulligan, Gheorghiu, & Reyes-Ortiz, 1999). Existential well-being is another way of measuring life satisfaction. Scales like the Spiritual Well-Being Scale show a positive relationship between positive feelings about life and spiritual or religious factors (Bufford, Paloutzian, & Ellison, 1991). Data suggests that professionals who make several small changes in their approach to religious commitments may enhance health care outcomes (Matthews et al., 1998). Mental health professionals need to pay attention to spiritual factors since

the relationship between these factors correlates so positively with factors of well-being and life satisfaction.

Prayer, intrinsic and extrinsic religious factors are clearly related to people's well-being. Physically, mentally, emotionally, and spiritually people report more positives when prayer and religious factors are part of their lives. This research will explore trends that have been studied in many groups. The researcher assumes to find many of the same patterns within the sample population.

CHAPTER THREE

Methodology

Introduction

Chapter three describes the participants, instruments, and results of the data collection. The instruments and study design are both common in the area of spirituality and health. Little research is available about the spirituality of the target population. Understanding if this population differs from the norms may lead to a better understanding of the strengths or weakness in the target population.

Participants

A convenience sample of 60 over-night patients at a Midwestern hospital were asked to fill out 70 multiple choice questions. Participants were patients in the Behavioral Health unit of the hospital between the months of May and September of 2002. The opportunity to participate in the study was given to participants attending the morning coping skills group.

Measures - Instrumentation

Each subject completed twelve demographic questions (Appendix B) and three measurement instruments: Structure of Prayer Scale (Appendix C), Spiritual Well-Being Scale (Appendix D), and Intrinsic Religious Motivation Scale (Appendix E).

The Structure of Prayer Scale assesses categories of prayer (Luckow, Ladd, Spilka, McIntosh, Parks, & Laforett, 1997). This 28-item measure uses a 6-point Likert scale to measure six types of prayer: confession, petition, ritual, meditation-improvement, habit, and compassionate petition (Luckow et al., 1997). This measure allows the researcher to determine the type of prayer the participant prefers and uses.

The Spiritual Well-Being Scale is used to measure subjective existential well-being and subjective religious well-being; this is a twenty-item 6-point Likert scale. This measure provides an understanding of a person's religious well-being as well as an understanding of the person's subjective social psychological well-being (Paloutzian & Ellison, 1982).

The Intrinsic Religious Motivation Scale is a ten-item 6-point Likert scale. This scale is used to measure the participant's perceived internal relationship with God (Hoge, 1972). A higher score denotes a stronger perceived internal relationship with God. Some items are reverse scored; these items ask about external motivators for religious convictions.

Procedures - Data Collection

Approximately twice a week the researcher would attend the last 15 minutes of the 10:45 a.m. coping skills group. This group was held at the Behavioral Health Unit of the hospital.

The researcher explained that anyone who had already participated could not participate a second time. Patients that needed a guardian signature were not invited to participate. A staff member would usually remove these group members before the researcher started talking or they were allowed to sit and observe. The researcher then explained the study and asked for the participants' approval before collecting any data. Everyone was informed of the right to decline participation. A copy of the informed consent sheet (Appendix A) was explained. Participants were told the researcher would hold the informed consent confidential; another copy was given to the client. Patients who did not wish to be part of the study were allowed to leave the room or stay with the group; about quarter of the group left each time.

After agreeing to participate, packets were handed out. Participants were instructed to read and sign the consent forms. Participants were asked to circle answers directly on the instruments and demographic questions. Staff was available to help if a participant had difficulty reading the study. The researcher was also available to answer questions. If staff or the researcher observed that a participant could not understand the demographic questions, (example, if the participant gave an obviously wrong age) the researcher would not use the data from those surveys. This did not happen in this specific study.

Each participant received a packet containing two copies of the informed consent sheet (Appendix A), the demographic questions (Appendix B), and the three instruments (Appendix C-E). While the demographic questions were always at the beginning of the packets, the scales were arranged in six ways to control for order effects. Each instrument was a different color (see below).

Blue	Structure of Prayer Scale
Red	Spiritual Well-Being Scale
Green	Intrinsic Religious Motivation Scale

Results – Data Analysis

Means were calculated and compared. A Pearson Correlation was used to assess the relationship between all measures. Efforts were made to control for any order effects and a One Way Analysis of Variance was used to investigate these effects.

Assumptions:

The researcher assumed that participants' cognitive processes and/or delusional states did not interfere with comprehension of the measures. Participants were legally able to give consent to participate in this study, even though many could not leave the hospital. The researcher also assumed that

if any participants' educational level was too low to read or understand the material, they would ask for help.

Limitations:

This study is limited in the sense that people with different mental health issues were not represented. Depressed individuals were largely represented in group, but people with disorders like social phobias were more often in their rooms and did not get a chance to participate in the study.

A second limitation is the validity of these measures on this population. While these measures have validity, there are not any previous studies that demonstrate the studies have validity in this population. Finally this study was not diverse geographically, religiously, or financially. This study is not able to conclude anything in these areas.

CHAPTER FOUR

Results

This chapter will present the results of the study on “The Relationship of prayer and internal religiosity to mental and spiritual well-being.” The descriptive statistics will be reported first. Data collected on each of the research hypotheses will then be given. Order effects were analyzed and none were found.

Demographic Information

The sample for this study consisted of 61% (n=36) females, 39% (n=23) males. People were equally distributed between the age ranges of eighteen to sixty-five. Caucasians represented 86% (n=51) of the sample, while 12% (n=7) represented other races, approximately 2% (n=1) refused to answer.

People who belonged to an organized religion comprised 50.8% (n=30) of the sample, while 49.2% (n=29) did not belong to an organized religion. Seventy-four percent (n=44) of the sample considered themselves Christian, while twenty-four percent (n=14) marked the “other” category (non-atheist), and two percent (n=1) were atheists.

The population also had significant and reoccurring mental health issues. Approximately 58% (n=34) stay at the hospital more than once a year and 69% (n=41) have a stay of three days

or longer. Depression-suicide issues made up 49.2% (n=29) of the sample, while 11.9% (n=7) were in the hospital due to alcohol or drug use, 18.6% (n=11) were in the hospital for two or more reasons, 8.5% (n=5) had anxiety or bipolar problems, the rest of the sample 11.8% (n=7) left this data blank or listed other reasons for being in the hospital.

Hypothesis 1

The researcher hypothesized that the levels of well-being and internal religiosity will match that of the norms for the general population. Five groups of norms for the Spiritual Well Being Scale are listed below: Various religious groups ranged from 82 to 109, medical outpatients averaged 99, nonreligious sociopathic convicts averaged 76, and the combined scores on sexually abused, eating disorder, and outpatient counselees was 83, inpatient eating disorder patients averaged 77 (Paloutzian & Ellison, 1982). The mean score of this study's population was 78.23.

The norms for the Intrinsic Religious Motivation Scale are for a group of parishioners; the parishioners group averaged 50 percent below the maximum score (Hoge, 1972). The mean score for this study's population was 66 percent below the maximum score.

Hypothesis 2

There is a positive relationship between subjective existential well-being and subjective religious well-being within the sample. A Pearson Correlation analysis was run on the data pertaining to this hypothesis. The results indicated a significant positive correlation (r=.550) to a confidence level of .001, therefore the hypothesis is accepted.

Hypothesis 3

There is a positive correlation between the Spiritual Well-Being Scale and The Intrinsic Religious Motivation Scale within the sample. A Pearson Correlation analysis was run on the data pertaining to this hypothesis. The results indicated a significant positive correlation (r=.681) to a confidence level of .001, therefore the hypothesis is accepted.

Hypothesis 4

There is a positive correlation between Intrinsic Religious Motivation Scale and stronger prayer affinity for the following types of prayer: confession, petition, ritual, meditation-improvement, habit, and compassionate petition. A Pearson Correlation analysis was run on the data pertaining to this hypothesis. The results indicated some significant positive correlations, confession (r=.477) is significant to a confidence

level of .001, petition (r=.084) is not significant, ritual (r=.134) is not significant, meditation-improvement (r=.647) is significant to a confidence level of .001, habit (r=.627) is significant to a confidence level of .001, compassionate petition (r=.588) is significant to a confidence level of .001. Therefore the hypothesis is neither accepted nor rejected.

Hypothesis 5

There is a positive correlation between the Spiritual Well-Being Scale and stronger prayer affinity for the following types of prayer: confession, petition, ritual, meditation-improvement, habit, and compassionate petition. A Pearson Correlation analysis was run on the data pertaining to this hypothesis. The results indicated some significant positive correlations, confession (r=.433) is significant to a confidence level of .002, petition (r=.114) is not significant, ritual (r=.222) is not significant, meditation-improvement (r=.704) is significant to a confidence level of .001, habit (r=.668) is significant to a confidence level of .001, compassionate petition (r=.642) is significant to a confidence level of .001. Therefore the hypothesis is neither accepted nor rejected.

CHAPTER FIVE

Discussion

While the research shows how religion and spirituality are important to health and well-being, many people in society continue to ignore religious factors in health and well-being. Only half of medical schools offer classes in health and spirituality (Matthews, D. A., and Clark, C. 1998). Including the schools that offer these classes, it is unclear if any schools of medicine or psychology schools require classes on the importance of religion.

While many in the helping field may not be embracing religious solutions to health problems, many religious people know the benefits of religion and spirituality. Many religious people have long believed that having a relationship with God correlates with well-being and life satisfaction and the previously stated research supports their long held beliefs. More and more research is showing the important relationship between religion or spirituality and health and this study involving inpatient mental health clients continues that trend. The average scores for this sample does give insights into this studied group.

The average score for this sample of inpatient mental health clients is closest to the average for inpatient eating disorders reported in the research surveyed by Bufford,

Paloutzian, & Ellison (1991). Little can be said about the similarity between this study and the research surveyed by Bufford, Paloutzian, & Ellison (1991). This study on the relationship between well-being and mental health was conducted in part due to the small amount of knowledge about inpatient treatment facilities for psychological issues.

The scores for these inpatient mental health clients are low in comparison to most other groups listed in the norms of Spiritual Well-Being (SWB) studies. Reasons for this are unknown, but a sense of control or “hardiness” maybe part of the reason. Research by Bissell and Hardin (1995), showed a correlation between scores on the SWB scale and the factor of “hardiness”, which include having control, enjoying challenge, and commitment to finishing things. Many inpatient psychiatric patients are stripped of control, are clearly seeking help with their challenges instead of enjoying them, and many are at rock bottom. These characteristics may have to do with why this population’s scores are so much lower than most norm groups. Bufford, Paloutzian, & Ellison, (1991) noticed this same trend in the research they discuss about inpatient treatments. Research discussed by Ellison and Smith (1991), also states that patients staying in hospitals have lower well-being scores than those not staying in hospitals.

Interestingly, in the current study SWB scores were lower for inpatient participants than most other groups. However, the current study did find internal factors to be greater than the norms of the original sample cited in Hoge (1972). With the lower amount of studies on internal factors and with only one norm group in the original study by Hoge (1972), little can be understood from this difference. One possible reason for any difference could be the needs of the inpatient population. A study by Bade and Cook (1997) found correlations to prayer when participants asked God for assistance and calmness. Since people often pray when in need of assistance and calmness, further research might show that those in need are more involved in internal religiosity, such as prayer. This assertion is not supported by this research. Internal religious focus did positively correlate with well-being, leading one to wonder about a possible causal relationship. The same can be said for the positive correlation between well-being and prayer.

In this study on the relationship between mental health and spirituality, the prayer types of confession, meditation-improvement, habit, and compassionate petition had a positive correlation to the well-being scores. Inpatient mental health clients that partake in religious activities, especially of an internal nature, are seeing the positive life benefits discussed in other studies. Hale (2003) discusses over ten examples where

experts discuss studies that show health and emotional upturns that positively affect the lives of those involved. The spiritual involvement leading to better feelings about life was also seen in this study. These general life feelings are often measured with existential well-being scales.

The correlation between existential well-being and religious well-being was significant for the inpatient mental health clients studied. This sample shared this similarity with data from the Spiritual Well-Being Scale. In Bufford, Paloutzian, & Ellison (1991) discussion about the norms for the Spiritual Well-Being Scale, found positive correlations between healthy spirituality and other well-being. The same positive correlation was seen in the study by Bissell and Hardin (1995).

Both existential and religious well-being factors are positively correlated with four types of prayer: confession, meditation-improvement, habit, and compassionate petition. Poloma (2001) found prayer to relate to overall happiness with life. Other studies summarized by Poloma (2001) found that high scores on prayer experience positively correlated with satisfaction, general happiness, and existential well-being. The inpatient mental health clients studied experienced a positive relationship between prayer and well-being.

From this research we can conclude that this sample population sees the same relationships between existential and

religious well-being and prayer as norm groups that have been previously tested. Internal factors may be an area this group can rely on to help them with their mental health problems. Lower scores (than most groups) in well-being may be a factor that leads to more mental health problems or vice versa. This is an area that should be explored. Relationship with prayer is clearly positive. While more people benefit from spirituality, researchers must keep looking for deeper ways to understand the relationship between mental health and well-being and religion or spirituality.

One area that needs more research is the area of intrinsic religiosity. Although not as well researched as extrinsic religiosity, when the internal relationship with God is studied, stronger correlations are evident. Understanding this dynamic will help mental health professionals better understand their patients. In addition to a greater understanding of the inpatient mental health population, understanding more of the correlations between well-being and religiosity can lead to further research on causal differences.

Understanding the relationships between spiritual and religious factors also helps mental health professionals better understand how the client might be experiencing internal well-being. Mental health professionals can be more successful at

helping clients become more satisfied with life when they have a clearer view of common patterns.

Since doctors and mental health professionals serve a great number of people, research about the well-being of all populations is important. A group that is often the most in need of extra help in feeling better is patients in a mental health unit of a hospital. There is not a lot of research on patients staying in mental health units. Intrinsic religiosity and well-being in this population is an area of research that needs more investigation.

Limitations

While this study did provide some insights into the inpatient mental health clients, there are limitations to this study. This study is limited in the sense that mental health issues were not controlled. In replicating this study and in future studies, objective controls on disorder could lead to a clearer view of how different disorders correlate with well-being. Psychiatrist or psychologist diagnosis could be used to assign groups. This study is limited to a broad understanding of the relationship between mental health and spirituality or religion; nothing is specific to any disorder.

The relationship of specific disorder to prayer preferences also cannot be understood from this study, due to the lack of variety and objective measures for the disorder factor.

Correlating specific disorders with prayer preference or lack of prayer preference could provide insight into the relationship between spirituality and mental illness. These prayer studies could group disorders and with each group and do pre/post testing on prayer use and disorder symptoms. These studies could give insight into which types of prayer are most effective in decreasing the symptoms of a specific disorder. This study is limited to understanding the relationships between prayer, well-being, and spiritual or religion for inpatient mental health clients; no causal relationships can be claimed.

While research in this area continues, care for those whose bodies and minds are in need of repair needs to focus on the whole person. People function physically and mentally but a strong spiritual component, often fulfilled through religion and prayer to God, is also necessary in the care of fellow human beings.

REFERENCES

Association for Transpersonal Psychology. (2004). Retrieved April 2004, from http://www.atpweb.org/

Ayele, H., Mulligan, T., Gheorghiu, S., Reyes-Ortiz, C. (1999). Religious activity improves life satisfaction for some physicians and older patients. *The American Journal of Geriatric Sociology, 47*(4), 453-455.

Bade, M.K., Cook S.W. (1997). *Functions and perceived effectiveness of prayer in the coping process.* Presented paper. American Psychological Association: Chicago, 1997.

Bissell, L. D., & Hardin, S. I. (1995). *Relationship Between Religiosity, Spirituality and Subjective Well-Being.* Presented paper. American Psychological Association: Chicago, 1995.

Bufford, R. K., Paloutizian, R. F., & Ellison, C. W. (1991). Norms for the spiritual well-being scale. *Journal of Psychology and Theology, 19*(1), 56-70.

Dossey, L. (Presenter), & Cunningham, Dr. (Presenter). (1996). *Answered prayers? Investigating the healing power of prayer* (Film). (Available from the Canadian Broadcasting Corporation, Films for the Humanities and Science, Princeton, NJ)

Duke University. (1998). Having religious faith can speed recovery from depression in older patients. *Today's Chiropractic, 27*(4), 26. Retrieved September 9, 2001 from: ehostvgw10.epnet.com

Ellison C. W. & Smith J. (1991). Toward an integrative measure of health and well-being. *Biola University, 19(1),* 35-48.

Hales, D. (2003, March 23). Why prayer could be good medicine. Pioneer Press, pp. Parade, 4-5.

Hoge, D. R. (1972). Intrinsic religious motivation scale. In P. C. Hill & R. W. Hood (Eds.), *Measures of religiosity* (p. 135-137). Birmingham, AL: Religious Education Press.

Jones, S. L. (1996). A constructive relationship for religion with the science and profession of psychology: Perhaps the boldest model yet. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 113-148). Washington, DC: American Psychological Association.

Kemp, H. V. (1996). Historical perspective: Religion and clinical psychology in America. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 71-112). Washington, DC: American Psychological Association.

Larson, D. B., Sherrill, K. A., Lyons, J. S., Craigie, F. C. Jr., Thielman, M. A., Greenwold, M. A., & Larson, S. S.

(1992). Associations between dimensions of religious commitment and mental health reported in the American Journal of Psychiatry and Archives of General Psychiatry: 1978-1989. *The American Journal of Psychiatry, 149*(4), 557-559.

Luckow, A., Ladd, K. L., Spilka, B., McIntosh, D. N., Parks, C., & Laforett, D. (1997). The structure of prayer. In P. C. Hill & R. W. Hood (Eds.), *Measures of religiosity* (pp. 70-72). Birmingham, AL: Religious Education Press.

Matthews, D. A., & Clark, C. (1998). *The faith factor.* New York: Penguin Putnam, Inc.

Matthews, D.A., McCullough, M.E., Larson, D.B., Koenig, H.G., Swyers, J.P., Milano, M.G. (1998). Religious Commitment and Health: A Review of the Research and Implications for Family Medicine. *Archives of Family Medicine, 7(2),* 118-124. Retrieved May 1, 2004, from http://archfami.ama-assn.org/cgi/content/abstract/7/2/118

McKinney, J.P. and McKinney, K.G. (1999). Prayer in the lives of late adolescents. *Journal of Adolescence, 22, 279-290.*

McNeil, R. (1997). Science of Religion, William James. Malaspina University-College, January 9, 1997. Retrieved April 16, 2004, from http://www.mala.bc.ca/~mcneil/lec/jamesw2.txt

Merriam-Webster's collegiate dictionary (10th ed.). (1993). Springfield, MA: Merriam-Webster.

Mishlove, J. (Host). (1987). *Thinking allowed: Spirituality and psychology* (Film). (Available from Projective General Productions, Oakland, CA)

Moberg, D.O. (2001). *Aging and Spirituality.* New York: Haworth Press, Inc.

McCullough, M.E. Larson, D.B. (1999). Prayer. In W.R. Miller (Ed.), Integrating Spirituality Into Treatment (pp. 85-110). Washington D.C.: American Psychological Association.

Pargament, K. I. (1997). *The psychology of religion and coping.* New York: Guilford Press.

Palmer, P.J. (1983). *To know as we are known.* New York: HarperCollins.

Paloutzian, R. F., & Ellison, C. W., (1982). Spiritual well-being scale. In P. C. Hill & R. W. Hood (Eds.), *Measures of religiosity* (p. 382-385). Birmingham, AL: Religious Education Press.

Poloma, M. M. (1993). The effects of prayer on mental well-being. *Second Opinion 18*(3). Retrieved October 25, 2001, from http://ehostvgw11.epnet.com

Poloma, M.M, & Pendleton, B.F. (1989). Exploring types of

prayer and quality of life: A research note. *Review of Religious Research, 31,* 46-53.

Purdue University. (2004). Jung's theories and research and how they apply to religion. Retrieved April 16, 2004, from http://web.ics.purdue.edu/~mcgratke/theory.htm

Stanford Encyclopedia of Philosophy, (2003). William James. Retrieved April 16, 2004, from http://plato.Stanford.edu/entries/james

Wallwork, E., & Wallwork, A. S. (1990). Psychoanalysis and religion: Current status of a historical antagonism. In J. H. Smith & S. A. Handelman (Eds.), *Psychoanalysis and religion* (pp. 160-173). Baltimore, MD: Johns Hopkins.

Waring, N. (2000). Can Prayer Heal? *Hippocrates, August,* 22-24.

Appendix A

Consent Forms for Participation in Research

This 70-item study will take approximately 20 minutes to complete. Questions include questions about your demographics, prayer, your feelings on spiritually and non-spiritually well-being, and personally religious commitment. The goal of this study is to better understand the relationship between the above topic areas. Participants who finish the study will receive a fast food coupon.

Before completing the questionnaire, we would like you to read and then sign this consent forms, indicating that you understand the potential risks and benefits of participation, and that you understand your rights as a participant. If you have any questions, please contact Bill Gabler, the primary researcher, at 715-456-3898.

RISKS
Participants can talk to staff about any uncomfortable feelings that may arise from answering these questions. Your responses are completely confidential.

BENEFITS
Although the results of this study may be of benefit to others in the future, there is no direct benefit to you by participating in this study. Benefits to society include a better understanding of the relationship between mental health and spirituality. This study may contribute to a base of research that leads to spiritual interventions aimed at improving mental health.

CONFIDENTIALITY OF RESPONSES
Your answers are strictly confidential. Only the primary researcher or his/her designee will have access to the confidential raw data.

RIGHT TO WITHDRAW OR DECLINE TO PARTICIPATE
Your participation in this study is entirely voluntary. You may choose not to participate without any adverse consequences to you. Should you choose to participate and later wish to withdraw from the study, you may discontinue your participation at that time without incurring adverse consequences.

NOTE: Questions or concerns about the research study should be addressed to Bill Gabler, the researcher, at 715 456-3898 or Sally Hage, the research advisor, 715-232-3094. Questions about the rights of research subjects can be addressed to Sue Foxwell, Human Protections Administrator, UW-Stout Institutional Review Board for the Protection of Human Subjects in Research, 11 Harvey Hall, Menomonie, WI, 54751, phone (715) 232-1126.

A copy of the results of the study will be available to all participants. Participants should call the researcher to obtain a copy of the results.

I attest that I have read and understood the above description, including potential risks, benefits, and my rights as a participant, and that all of my questions about the study have been answered to my satisfaction. I hereby give my informed consent to participate in this research study.

Signature _____ Date _____

Please sign both informed consent sheets. Keep one for yourself and leave one for the researcher.

Appendix B

Please circle the most appropriate answer on this sheet.

1. What is your gender?

Male	A
Female	B

2. What is your age?

Under 18	A
18-25	B
26-35	C
36-50	D
51-65	E
Over 65	F

3. What is your race?

Arab	A
Asian	B
Black	C
Caucasian/white	D
Hispanic	E
Native American	F

Other (Please write in space provided)

_____

4. What is your approximate yearly income?

Less than $10,000	A
$10,000-$20,000	B
$20,001-$30,000	C
$30,001-$40,000	D
$40,001-$50,000	E
Over $50,000	F

5. What is the highest level of education you have completed?

Less than 8th grade	A
8th Grade	B
High School	C
Two year degree	D
Four year degree	E
Graduate degree	F

6. Do you currently belong to an organized religion?

Yes	A
No	B

7. What best describes your religious faith?

Atheist (No Religious faith)	A
Buddhist	B
Christian	C
Islam	D
Jewish	E
Other	F

In the space provided please further describe your religious tradition. If you answered A please skip to question 9.

_____

8. How regularly do you attend an organized religious service?

Almost never or never	A
A couple of times a year	B
One time a month	C
One time a week	D
Two to five times a week	E
More than five times a week	F

9.What brings you to the hospital?

Accident	A
Mental illness	B
Emotional or mental stress	D

Other_____

10.How long have you been in the hospital?

Less than a day	A
One to two days	B
Three to six days	C
One week to almost two weeks	D
Two weeks to a month	E
Over a month	F

11.How often do you go to the hospital and stay at least one night?

Never have before	A
Less than once every 5 years	B
Once in one to five years	C
Once every 6 to 11 months	D
Once every 1 to 5 months	E
More than once a month	F

12. What best describes your diagnosis?

I came to the hospital for other reasons	A
Depression-Suicide	B
Anxiety or Bipolar	C

	Alcohol or drug use D Psychiatric issues (hallucinations etc.) E Criminal Behavior F

Appendix C

Please circle the most appropriate answer on this sheet.

Structure of Prayer Scale

Prayer or meditation is approached in a wide variety of fashions. For the purposes of this study please think of "pray" and "meditate" as the same sort of practice. We would like you to indicate for each of the following statements the position that most accurately reflects your personal practices. Please use this scale for your answers:

1 = Strongly disagree 2 = Moderately disagree 3 = Slightly disagree
4 = Slightly agree 5 = Moderately agree 6 = Strongly agree

1. When I pray alone, I have a ritual that I adhere to strictly.	1	2	3	4	5	6
2. Through deep prayer I am able to know God better.	1	2	3	4	5	6
3. It is important to me to tell God about my sins or faults.	1	2	3	4	5	6
4. When I pray, I want to share my life with God.	1	2	3	4	5	6
5. I usually pray for God to make me a better person.	1	2	3	4	5	6
6. Pray to give thanks for all God has done for me.	1	2	3	4	5	6
7. When I feel guilty about something, it helps to tell God about it.	1	2	3	4	5	6
8. When God has answered my prayers, I usually give thanks.	1	2	3	4	5	6
9. My prayers are like rituals; they have a regular, orderly sequence.	1	2	3	4	5	6
10. I usually say a prayer before each meal.	1	2	3	4	5	6
11. I like to say prayers for people about whom I care very much.	1	2	3	4	5	6
12. I always pray before I go to sleep.	1	2	3	4	5	6
13. I must admit that I usually pray to get something.	1	2	3	4	5	6
14. Confession is important to me because it helps me lead a more respectable life.	1	2	3	4	5	6
15. When I pray, I ask God for special favors.	1	2	3	4	5	6
16. Prayer helps me keep my life balanced and happy.	1	2	3	4	5	6
17. When I pray, I confess to God the things I should not have done.	1	2	3	4	5	6
18. Usually when I feel unable to help my loved ones, I ask God for help.	1	2	3	4	5	6
19. I ask God to help others when I am unable to.	1	2	3	4	5	6
20. When I pray, I have certain words or phrases that I repeat a number of times.	1	2	3	4	5	6
21. In my prayers I like to express my recognition for what God grants me.	1	2	3	4	5	6
22. Most of my prayers are for God to solve problems.	1	2	3	4	5	6
23.When I finish praying, I feel like a better person.	1	2	3	4	5	6
24. I pray for other people.	1	2	3	4	5	6
25. A morning prayer helps me cope with the world during the day.	1	2	3	4	5	6
26. Prayer is a way for me to connect with my inner spirit.	1	2	3	4	5	6
27. When I pray, I feel secure.	1	2	3	4	5	6
28. I pray daily.	1	2	3	4	5	6

Appendix D

Please circle the most appropriate answer on this sheet.

Spiritual Well-Being Scale

For each of the following statements, circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

1 = Strongly disagree 2 = Moderately disagree 3 = Slightly disagree
4 = Slightly agree 5 = Moderately agree 6 = Strongly agree

1. I don't find much satisfaction in private prayer with God.	1	2	3	4	5	6
2. I don't know who I am, where I came from, or where I'm going.	1	2	3	4	5	6
3. I believe that God loves me and cares about me.	1	2	3	4	5	6
4. I feel that life is a positive experience.	1	2	3	4	5	6
5. I believe that God is impersonal and not interested in my daily situations.	1	2	3	4	5	6
6. I feel unsettled about my future.	1	2	3	4	5	6
7. I have a personally meaningful relationship with God.	1	2	3	4	5	6
8. I feel very fulfilled and satisfied with life.	1	2	3	4	5	6
9. I don't get much personal strength and support from my God.	1	2	3	4	5	6
10. I feel a sense of well-being about the direction my life is headed in.	1	2	3	4	5	6
11. I believe that God is concerned about my problems.	1	2	3	4	5	6
12. I don't enjoy much about life.	1	2	3	4	5	6
13. I don't have a personally satisfying relationship with God.	1	2	3	4	5	6
14. I feel good about my future.	1	2	3	4	5	6
15. My relationship with God helps me not to feel lonely.	1	2	3	4	5	6
16. I feel that life is full of conflict and unhappiness.	1	2	3	4	5	

	6					
17. I feel most fulfilled when I'm in close communion with God.	1	2	3	4	5	6
18. Life doesn't have much meaning.	1	2	3	4	5	6
19. My relation with God contributes to my sense of well-being.	1	2	3	4	5	6
20. I believe there is some real purpose for my life.	1	2	3	4	5	6

Appendix E

Please circle the most appropriate answer on this sheet.

Intrinsic Religious Motivation Scale

Please use the following scale to indicate your response to each statement listed below:

1 = Strongly disagree 2 = Moderately disagree 3 = Slightly disagree
4 = Slightly agree 5 = Moderately agree 6 = Strongly agree

1. My faith involves all of my life.	1	2	3	4	5	6
2. One should seek God's guidance when making every important decision.	1	2	3	4	5	6
3. In my life I experience the presence of the Divine.	1	2	3	4	5	6
4. My faith sometimes restricts my actions.	1	2	3	4	5	6
5. Nothing is as important to me as serving God as best I know how.	1	2	3	4	5	6
6. I try hard to carry my religion over into all my other dealings in life.	1	2	3	4	5	6
7. My religious beliefs are what really lie behind my whole approach to life.	1	2	3	4	5	6
8. It doesn't matter so much what I believe as long as I lead a moral life.	1	2	3	4	5	6
9. Although I am a religious person, I refuse to let religious considerations influence my everyday affairs.	1	2	3	4	5	6
10. Although I believe in my religion, I feel there are many more important things in life.	1	2	3	4	5	6

Hoge, D. R. (1972). A validated intrinsic religious motivation scale. *Journal for the Scientific Study of Religion, II,* 369-376.